CALIFORNIA COORDINATED CARE INITIATIVE: Development of the State Evaluation and Quality Measures Plan

Kenneth W. Kizer, MD, MPH

Quality and Evaluation Workgroup Meeting

Sacramento, CA

May 17, 2012

PRESENTATION PURPOSE

To provide a brief overview of some of the strategic issues that should be considered in evaluating *California's Coordinated Care Initiative*, including selection of performance measures, quality indicators and other metrics.

General Approach to Project Evaluation and Performance Measure Selection

1. What is the vision of the project and its guiding principles?
2. What are the strategic aims and "success factors" that we most want to know about (i.e., will be evaluated)?
3. Which strategic aims or purposes can be quantified, consistently and reliably measured and tracked?
4. What performance measures or other metrics for tracking progress towards achieving identified strategic aims have been validated?
5. For which of the performance measures can data be reasonably and reliably obtained given the parameters of the project?
6. Analyze the data….

Performance Measurement Problems for Dual Eligible Beneficiaries

- A very heterogeneous population due to it having been 'politically' defined
- The complexity of its physical, mental and social conditions and their intense service needs, as well as the extreme vulnerability of some subgroups
- Varied settings of care, types of providers, service needs and historical 'programmatic" rules has led to highly fragmented delivery of health care and supportive services
- Majority of available performance measures were developed for singular clinical conditions or care settings or specific programs
- Until recently, federal performance measurement programs primarily related to Medicare

DHHS/CMS Strategic Objectives

- "Triple Aim"
  - ✓ Better patient care experience
  - ✓ Improved quality
  - ✓ Reduced cost
- National Quality Strategy
  - ✓ Make care safer by reducing harm caused by delivery of care
  - ✓ Ensure patients and families are partners in their care
  - ✓ Promote effective communication and coordination of care
  - ✓ Promote most effective (evidence-based) prevention and treatment for the leading causes of mortality, starting with cardiovascular care
  - ✓ Promote wide use of best practices to enable healthy living
  - ✓ Make quality care more affordable by developing and spreading new healthcare delivery models

National Quality Forum MAP Vision for High-Quality Care

In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals.

Example of Another Vision Statement

The Veterans Health Care System will provide a seamless continuum of consistent and predictable high quality, patient-centered care that is of superior value.

**** Vision for Change* 1995**

California Coordinated Care Initiative: Strategic Aims

- Improve beneficiaries' quality of life, health care and satisfaction with the health care system
- Identify and eliminate existing sources of fragmentation and inefficiencies that result from the incongruities between both programs
- Develop financial models that drive streamlined and coordinated care through shared savings and elimination of cost shifting
- Create one point of accountability for the delivery, coordination and management of the full continuum of needed services
- Promote and measure improvements in health outcomes
- Slow the growth of Medi-Cal and Medicare costs

California Coordinated Care Initiative: Operational Aims

- Promote person-centered care planning
- Increase use of home- and community-based services
- Emphasize health promotion and disease prevention
- Streamline and simplify service delivery
- Enhance quality monitoring and enforcement
- Build on lessons learned from Medi-Cal and other care transitions

California Coordinated Care Initiative: "Achievable Principles" for Integrated Care

1. Provide a streamlined continuum of care that is easy for beneficiaries and caregivers to navigate
2. Ensuring high standards of quality of care
3. Helping beneficiaries return to their homes after an acute episode of care
4. Preserving beneficiary choice of providers
5. Preventing admissions to nursing facilities and providing robust and coordinated home- and community-based services
6. Increasing access to primary care
7. Providing financial support to mental health professionals to participate on care teams and provide caregiver training

California Coordinated Care Initiative: "Achievable Principles" for Integrated Care

8. Blending Medicare parts A and B funding with Medi-Cal dollars to expand flexibility in coverage
9. Blending home and community-based funding with Medicaid acute and long-term care institutional funding to align incentives to help people stay out of institutions
10. Using one set of riules for appeals, marketing, quality measures and reporting
11. Creating a rapid cycle monitoring and learning process so that integrated care models can be developed, improved, replicated and scaled as efficiently as possible

Dual Eligible Beneficiaries: Priority Concerns

- Care Transitions
- Utilization of Services
  - ✓ Potentially Avoidable Hospitalizations
  - ✓ Preventable Readmissions and Emergency Care
- Medication Management
- Mental/Behavioral Health Conditions
- Health Literacy
- Health homes
- Person- and Family-Centered Care

Dual Eligible Beneficiaries: Priority Concerns

- **Potentially Avoidable Hospitalizations (>80% due to 5 conditions**
  - ✓ **Congestive heart failure (22.9%)**
  - ✓ **COPD/asthma (17.0%)**
  - ✓ **Pneumonia (14.7%)**
  - ✓ **Dehydration (14.5%)**
  - ✓ **Urinary tract infections (12.5%)**
- **Mental/Behavioral Health Conditions**
  - **Depression**
  - **Alcohol and substance abuse**

National Quality Forum MAP Work

- Vision for high-quality care
- High-Leverage Opportunities for Improvement*
  - Quality of life
  - Care coordination
  - Screening and assessment
  - Mental health and substance abuse
  - Structural measures
- Proposed Measures
  - ✓ Starter Set
  - ✓ Expansion Set
  - ✓ Core Measure Set
  - ✓ Selected measures for HCBS
- Measurement Gaps

*Measurement has the potential to drive significant positive change

NQF MAP "Starter Set" Performance Measures

1. Screening for clinical depression and follow up plan (#0418)
2. CAHPS Survey (multiple #s according to setting of care)
3. Medical home system survey (#0494)
4. Initiation and engagement of alcohol and other drug dependence treatment (#0004)
5. Hospital-wide all cause unplanned readmission measure (#1789) or health plan all-cause readmissions (#1768)

NQF MAP "Expansion Set" Performance Measures Needing Modifications

1. Assessment of health-related quality of life – physical and mental functioning (#0260)
2. Medical home system survey (#0494)
3. Post discharge continuing care plan created (#0557)
4. Post discharge continuing care plan transmitted to next level of care provider upon discharge (#0558)
5. Screening for fall risk (#0101)
6. 3-item care transition measure (#0228)
7. Comfortable dying; pain brought to a comfortable level within 48 h of initial measurement (#0209)
8. Change in daily activity function as measured by the Activity Measure for Post-Acute Care (#0430)

Illustrative Other Metrics

- **High Impact Condition-Specific PMs**
  - **Cardiovascular care**
  - **Diabetes**
  - **Patient safety**
- **Utilization of Services**
  - ✓ **Hospital bed day rates**
  - ✓ **Avoidable hospitalizations (admissions and re-admissions)**
  - ✓ **Rates of institutionalization**
  - ✓ **Emergency services**
  - ✓ **Length of stay**
- **Cost/Expenditure**
  - ✓ **Risk-adjusted per capita costs**
- **Outcomes**
  - ✓ **Risk adjusted mortality rates**
  - ✓ **Hospital-specific mortality rates**

QUESTIONS…